AUTHORIZATION TO RELEASE INFORMATION
FOR THE PURPOSE OF APPLYING FOR A CONCEALED FIREARM PERMIT

PRINT LEGIBLY OR TYPE

NAME OF APPLICANT: _____ DOB: _____

ALIAS AND/OR PRIOR NAME(S): _____

Pursuant to 25 MRSA §2003(1)(E)(1), I authorize the **Augusta Mental Health Institute** and the **Bangor Mental Health Institute** of the Department of Behavioral and Developmental Services to disclose any record of whether I have ever been committed to the Augusta Mental Health Institute or the Bangor Mental Health Institute to:

_____
Issuing authority as defined at 25 MRSA §§2002(9), 2002-A (Identify organization and individual representative)

Issuing Authority
Mailing Address:_____
Issuing Authority Fax #: _____ Telephone # to verify receipt of fax:_____

Note: If information is requested to be faxed, a telephone number to verify the receipt of the fax is required. If a telephone number for verification is NOT provided, the information will be sent by regular mail.

I understand that the information requested is protected by law and cannot be released without my written permission, unless otherwise specifically permitted by law. I understand that I have the right to review information and material prior to its release. I understand I have the right to revoke this authorization in writing at any time by contacting the issuing authority identified above. I understand that my refusal to sign this release will cause my application for a concealed weapons permit to be rejected. I understand that if the issuing authority receives an affirmative response to its inquiry, I may be asked to authorize the release of additional information to determine my eligibility for a concealed firearm permit. Information disclosed to the issuing authority pursuant to this release is confidential pursuant to 25 MRSA § 2006.

This authorization is effective for ninety (90) days following my dated signature.

_____
Applicant Signature **Date**

_____
Witness Signature **Date**

APPLICANT: RETURN THIS FORM TO THE ISSUING AUTHORITY WITH YOUR PERMIT APPLICATION. RETAIN A COPY FOR YOUR RECORDS.

ISSUING AUTHORITY: Send completed form (or a copy) to

Augusta Mental Health Institute, PO Box 724, Augusta ME O4333-0724, attention Medical Records (fax 207-287-7127) AND Bangor Mental Health Institute, PO Box 926, Bangor ME 04401, attention Medical Records (fax 207-941-4029)